

## MEDICAL NECESSITY FOR AUTHORIZATION OF CATHETERS

This form is required for all MAA clients requesting sterile closed catheters. **Do not alter this form in any way.** The form may only be completed by a qualified provider, acting within the scope of their practice, and all spaces must be completed. The form must be signed and dated within 60 days of MAA receiving the request. This form will be required in addition to a prescription.

DATE OF REQUEST	DSHS PIC NUMBER
PATIENT NAME	
DIAGNOSIS	
ITEM REQUESTED	

*Please check all that apply to your patient:*

- The patient has/had documented recurrent urinary tract infections while on a program of clean cathing, twice within a 12 month period prior to beginning sterile cathing.

Please list the following:

- a) dates of UTI's \_\_\_\_\_
- b) antibiotics used \_\_\_\_\_
- c) attach/provide copy(s) of lab reports

**A urinary tract infection is indicated by a urine culture with more than 10,000 colony-forming units of a urinary pathogen and a concurrent presence of one or more of the following signs, symptoms, or lab findings. Check those that apply to your patient.**

- Fever State temperature in degrees \_\_\_\_\_
- Change in urinary urgency, frequency, or incontinence.
- Appearance of new, or increase in, autonomic dysreflexia (sweating, bradycardia, blood pressure elevation).
- Physical signs of prostatitis, epididymitis, orchitis.
- The patient is immunosuppressed (on a regimen of immunosuppressive drugs, cancer chemotherapy, or has AIDS).
- Pyuria (greater than 5 wbc's per high-powered field).
- Systemic Leukocytosis.

How many times per day does the patient catheterize?

- 2-4 times       4-6 times       6-8 times       8 times or more

ADDITIONAL COMMENTS

PHYSICIAN'S PRINTED NAME	REFERRING PHYSICIAN NUMBER
TELEPHONE NUMBER	FAX NUMBER
PHYSICIAN'S SIGNATURE	DATE